

105038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 7 7 6

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Preston Lawrence Adkins			2a. DATE OF DEATH MONTH DAY YEAR March 29, 1985			2b. HOUR 8:30A M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 26, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.			
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2 - Box 137 A				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Teacher		12b. KIND OF BUSINESS OR INDUSTRY Voc. School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2 - Box 137A / 21863	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence E. Adkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae E. Smack					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Alice L. Adkins, Snow Hill, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO - RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> <u>5 YEARS</u> <u>5 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>2/22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>H. Thompson</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/1/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY N. THOMPSON				22e. ADDRESS 902377 AGN STATION SALISBURY MD 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/2/85		23c. NAME OF CEMETERY OR CREMATORY Makemie Presbyterian		23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Norman F. Dennis, Snow Hill, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John K. [Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

107001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

12777

1. FOR
STATE REGISTRAR Arline Mae Churn

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arline Mae Churn			2a. DATE OF DEATH MONTH DAY YEAR 4 5 85		2b. HOUR 8 ⁰⁰ A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 3 08		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.		
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired waitress		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Gardinier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maud B. Hawkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-05-2003		17. INFORMANT ADDRESS Paul R. Lewis P. O. Box 2124 Falls River, Mass.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Carcinoma of the Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec. 3</u> , 19 <u>84</u> , to <u>April 5</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>April 1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Robert J. Reilly</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 4/5/85	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Reilly		22e. ADDRESS RT 3 Box 232 Snow Hill Md. 21863						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/5/85		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.		
24. FUNERAL DIRECTOR NAME Scott S. Miller		ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR APR 11 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

10000



113013

5/23/85 Item 4 L.J

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 2 7 7 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Primrose Finney			2a. DATE OF DEATH MONTH DAY YEAR 04 07 85		2b. HOUR 6:45p M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 03- 17 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Pocomoke City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Work		12b. KIND OF BUSINESS OR INDUSTRY Poultry
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Worcester	13c. CITY OR TOWN Stockton	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Teagle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzy Wallop		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-03-3654		17. INFORMANT ADDRESS Fieldie Callick - 107 Hartley St. Pocomoke Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sleeping Disorder. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-4-85 , 19____, to 4-7-85 , 19____, that (I) (we) lost saw the deceased alive on 4-4-85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul R. Fleury		DEGREE		22c. DATE SIGNED 4/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL R. Fleury		22e. ADDRESS 305 Tenth St Pocomoke City Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-13-85		23c. NAME OF CEMETERY OR CREMATORY Dees Chapel	
24. FUNERAL DIRECTOR NAME Edgar Wharton		ADDRESS Pocomoke, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.	
25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR		25c. DATE SIGNED APR 16 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH-16 30M 2/80
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.)

1



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 7 7 9

127162

1 - FOR
STATE
REGISTRAR

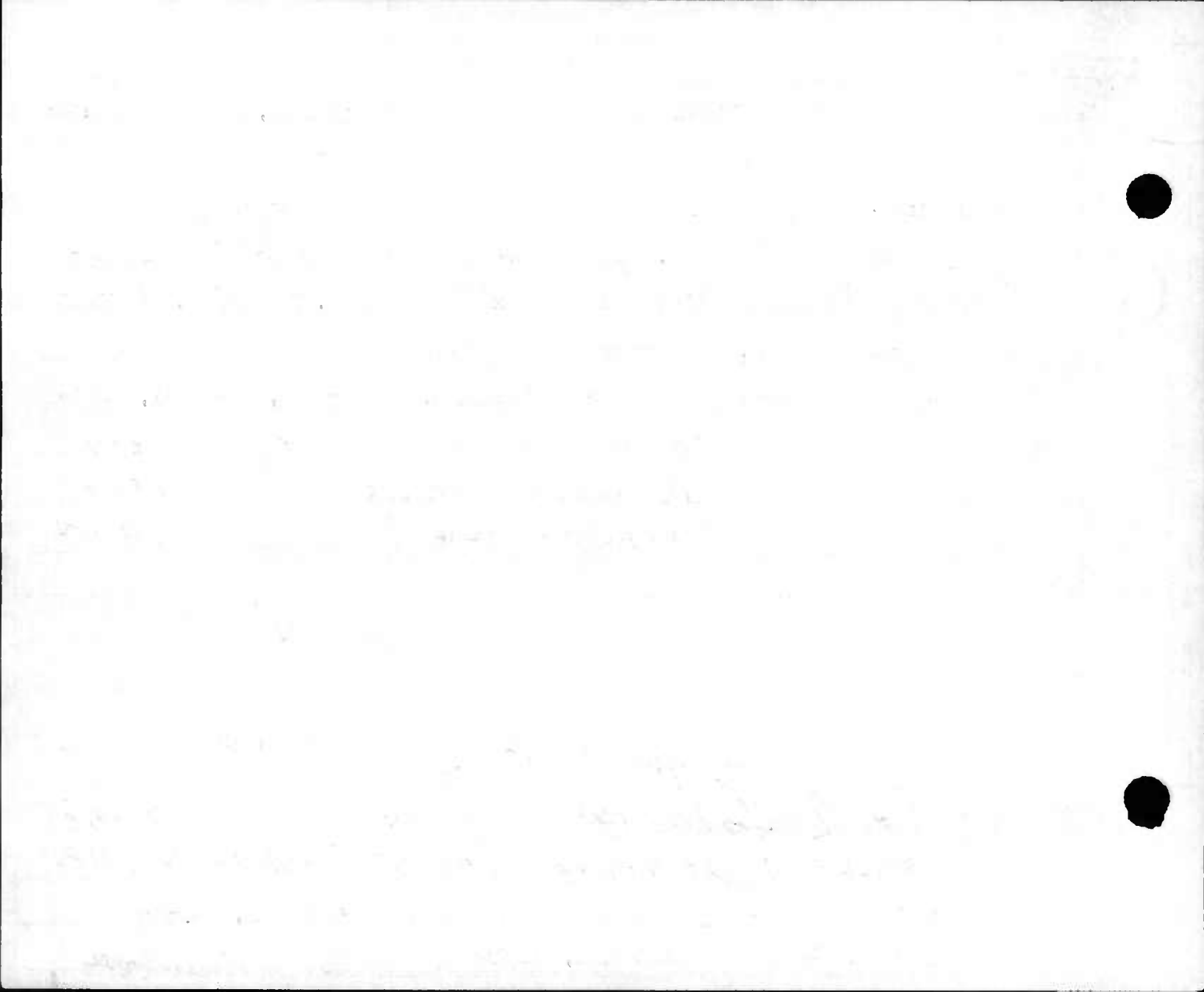
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie Elizabeth Henman			2a. DATE OF DEATH MONTH DAY YEAR April 26, 1985		2b. HOUR 2:30A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8/22/01		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 218 E. Federal Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Telephone	
13a. STATE Maryland				13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Henman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Anne Pettitt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Marie H. Brittingham, Snow Hill, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMBOLUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>FRACTURED HIP</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 DAY</u> <u>1 MONTH</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/25/85</u> , 19 <u>85</u> , to <u>4/26/85</u> , 19 <u>85</u> , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert C. Lamar, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. LAMAR, MD				22e. ADDRESS 104 BAY ST SNOW HILL, Md. 21843			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/28/85		23c. NAME OF CEMETERY OR CREMATORY Whatcoat Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill, Maryland	
24. FUNERAL DIRECTOR NAME Norman F. Dennis				25a. DATE REC'D. BY REGISTRAR MAY 02 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Twiss-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



105015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

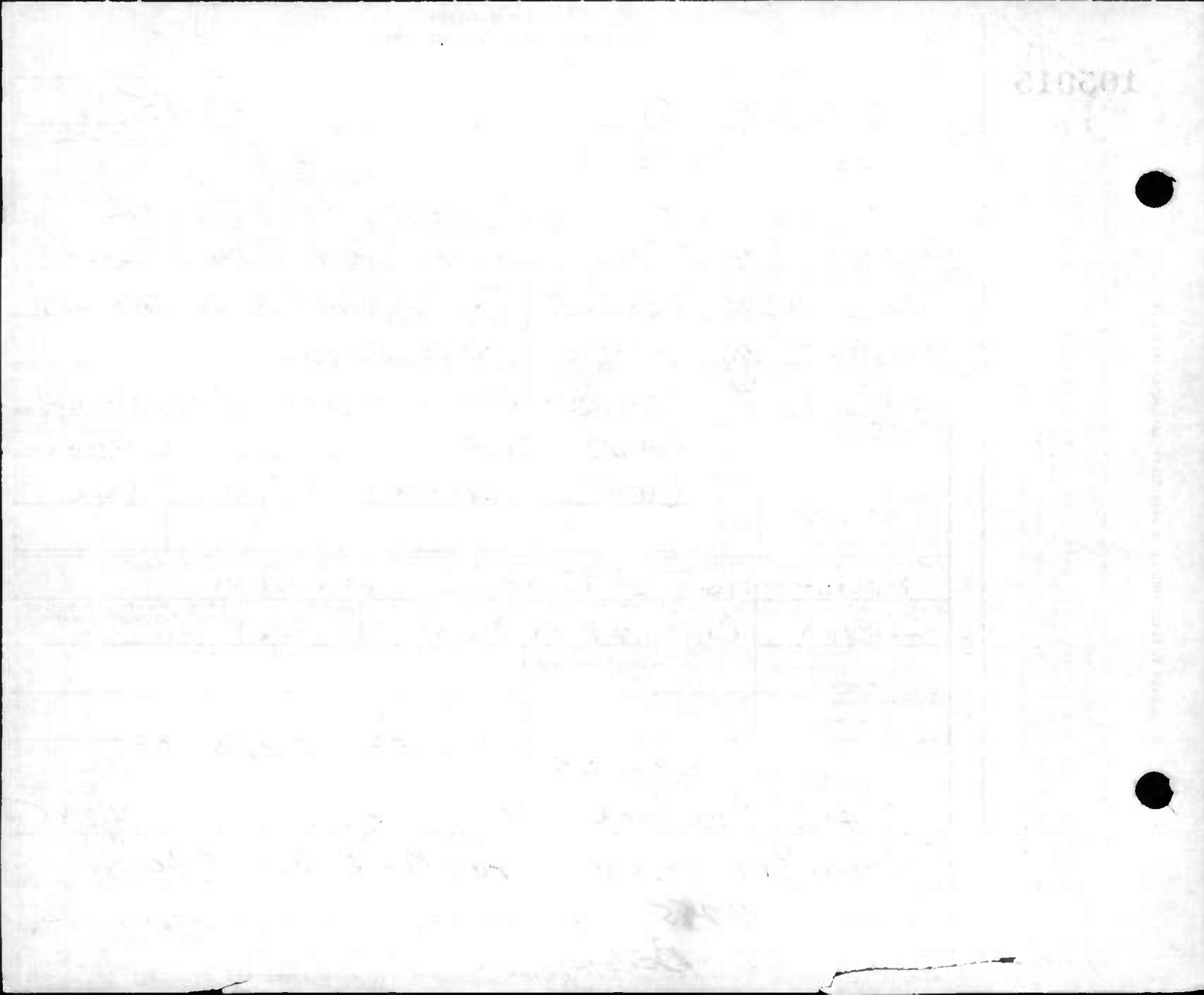
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILBERT J. NURDLE			2a. DATE OF DEATH MONTH DAY YEAR 4-4-85		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 9-30-21	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.		
10. CITY OR TOWN OF DEATH BERLIN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408 WILLIAMS ST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOWN OF BERLIN GOVT.		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 408 WILLIAMS ST.		
13a. STATE MD	13b. COUNTY WOR	13c. CITY OR TOWN BERLIN			
14. FATHER'S NAME FIRST MIDDLE LAST WILBERT M. NURDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MORRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II		16b. SOCIAL SECURITY NO. 214-12-6843	17. INFORMANT ADDRESS MYRTLE NURDLE BERLIN MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.
DUE TO, OR AS A CONSEQUENCE OF (b) DIFFUSE CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c)					1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) MALNUTRITION 2° INTESTINAL OBSTRUCTION					
19a. DATE OF OPERATION 2/28/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF COLON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/28 19 83 to 2/30 19 83 , that (I) (we) last saw the deceased alive on 2/30 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Bartkovich		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN BARTKOVICH		22e. ADDRESS PO BOX BLUE RD SACS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4-7-85	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WOR MD	
24. FUNERAL DIRECTOR NAME WRIGHT F.H. BERLIN MD.		25a. DATE REC'D. BY REGISTRAR APR 9 1985		25b. REGISTRAR'S SIGNATURE Wright F.H. Berlin	



127089

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 2 / 8 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE M. JONES			2a. DATE OF DEATH MONTH DAY YEAR April 19, 1985		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.		
10. CITY OR TOWN OF DEATH Pocomoke	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sheephouse Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Sheephouse Road 21851	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Will Blades		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Phillips			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lula Mae Blades R.F.D.#3, Box 260 Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/12, 1985, to 4/19, 1985, that (I) (we) last saw the deceased alive on 4/19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.G. Santiano, M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.G. Santiano, M.D.				22e. ADDRESS 100 8th St., Pocomoke City, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/22/85		23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem. Pocomoke Worcester Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.		24. FUNERAL DIRECTOR NAME ADDRESS Scott S. Nelson Pocomoke City, Md.			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 1 8 3
REG. NO.1 - FOR
STATE
REGISTER

1. DECEASED NAME (TYPE OR PRINT) Renzie Potter			2a. DATE OF DEATH MONTH DAY YEAR 04 22 85		2b. HOUR 8:25p M
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 12 28 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Pocomoke City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Sunship yard		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Somerset	13c. CITY OR TOWN Princess Anne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Potter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Taylor		13e. STREET ADDRESS Route 2 Box 250 21853	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-12-6133		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY arrest DUE TO, OR AS A CONSEQUENCE OF (b) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 85 , to 4/22 , 19 85 , that (I) (we) lost saw the deceased alive on 4/15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Mary Louise Fleury	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY LOUISE FLEURY		22e. ADDRESS 305 10th Street Pocomoke Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 27, 1985	23c. NAME OF CEMETERY OR CREMATORY John Wesley	23d. LOCATION CITY OR TOWN COUNTY Cottage Grove Md.
24. FUNERAL DIRECTOR NAME ADDRESS Norma J. Kirk Marine St., Md.		25a. DATE REC'D. BY REGISTRAR APR 25 1985	
25b. REGISTRAR'S SIGNATURE John A. Davidson			

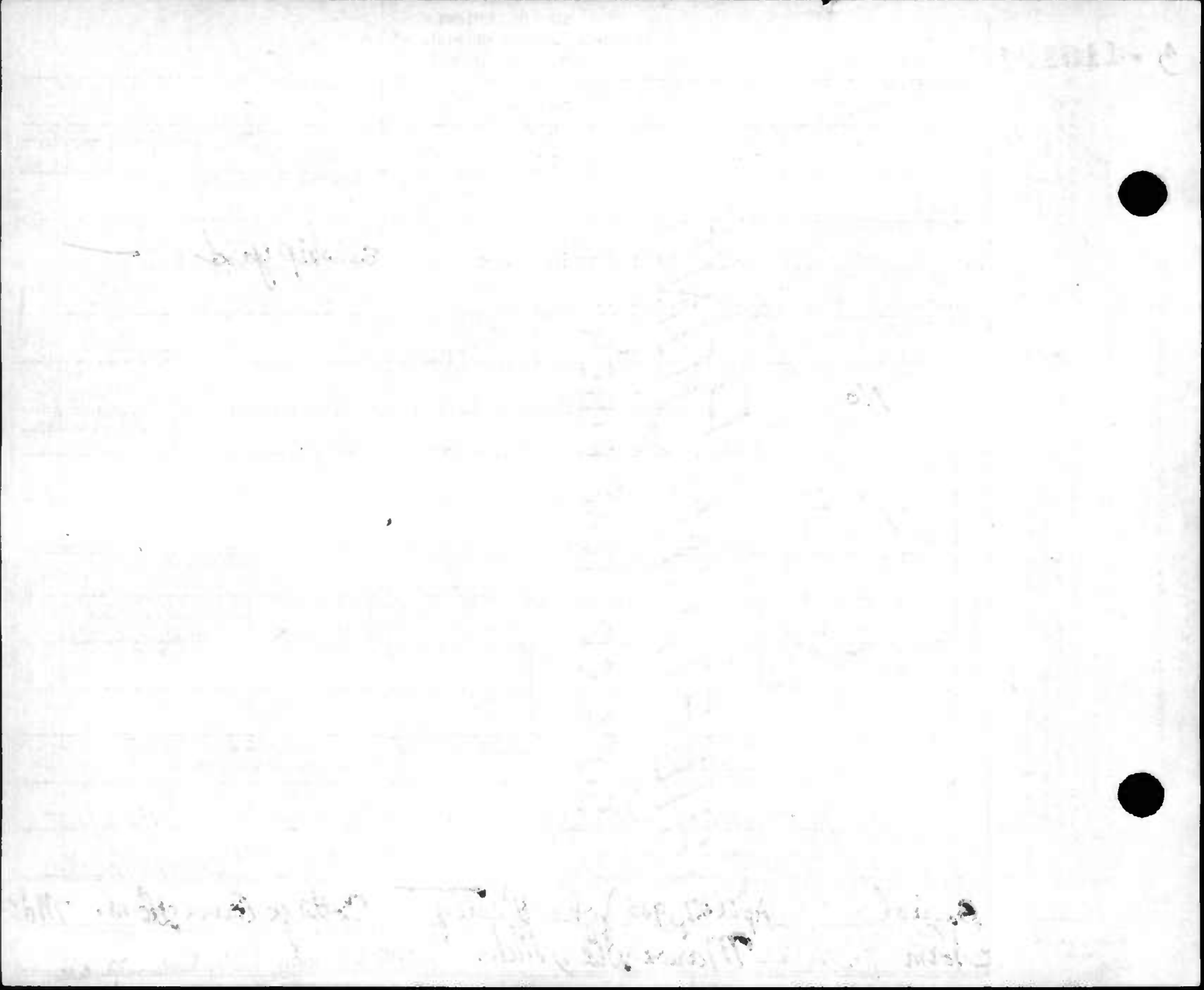
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP
DHMH-16 30M 2/80
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



134003

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial/transfer permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) HESTER MILARD STANT				2a. DATE OF DEATH MONTH DAY YEAR April 29, 1985		2b. HOUR 2:30 P.M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.			
10. CITY OR TOWN OF DEATH Pocomoke		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clarke Avenue Extended				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Clarke Avenue Extended	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Coutant		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Weinkoop		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 122-14-6616		17. INFORMANT William C. Stant	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6-2-70 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 6-2-70 , 19, to 4-29-85 , 19, that (if) (we) last saw the deceased alive on 4-29-85 , 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)		22b. SIGNATURE J. G. Santiano M.D.		22c. DATE SIGNED 5-2-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
J. G. Santiano M.D.		100 8th St. Pocomoke City, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/2/85		23c. NAME OF CEMETERY OR CREMATORY Salem Meth.Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.			
24. FUNERAL DIRECTOR NAME Scott S. Nelson		ADDRESS Pocomoke City, Md.		25a. DATE REC'D BY REGISTRAR MAY 09 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

DHMH-16 30M 2/80
(VRA 15, 4)

131007

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Nov. 12, 1954

With

Sample

Worcester

Box

New York

Housewife

Glenn Avenue Extended

Worcester

Glenn Avenue Extended

Worcester, Worcester

Worcester

Worcester

Content

W.

Route

133-14-6616 William W. Worcester, Worcester, Mass.
Glenn Ave., Ext.

no

Worcester, Worcester

Worcester

100 Glen St., Worcester, Mass.

Worcester, Mass.

Worcester, Worcester

Worcester, Mass.

Worcester

Worcester, Mass.